HENRY-MARTINSVILLE HEALTH DEPARTMENT
PO BOX 1032
MARTINSVILLE, VA. 24114

IMMUNIZATION ENCOUNTER FORM
INFORMED CONSENT FOR IMMUNIZATION

I hereby authorize the doctors, nurses or nurse practitioners of the Virginia Department of Health to immunize me or my child named above. I understand the risks and benefits of the immunizations checked below and have had the opportunity to ask questions. I have received VACCINE INFORMATION STATEMENTS or information sheets about the immunizations. I agree that my child's immunization record, date of birth and address may be shared with other health care providers. I understand that this information will be used by health care providers for the care of my child and for statistical purposes only. I understand that this information will be kept confidential. The Deemed Consent for blood borne diseases has been explained to me and I understand it. I understand that medical records must be kept for 5 years after death, 10 years after my last visit, or 5 years after age 18 for my minor child.

__*Diphtheria, tetanus, pertussis, haemophilus influenza B*
__*Oral polio vaccine*
__*Hepatitis B*
__*Measles, mumps, rubella*
__*Diphtheria, tetanus, acellular pertussis*
__*Haemophilus influenza type B*
__*Diphtheria, tetanus*

__*Tetanus, diphtheria*
__*Enhanced inactivated polio vaccine*
_____
(Other)
_____
(Other)
_____
(Other)

_____
Patient, Parent/Legal Guardian, Person Acting in Loco Parentis

Immunization History

Code	Date	Override

Contraindications/Exemptions

		Over ride	End date

Suggested Immunizations Due

Series	Code	Lot #	F/C	Actual Lot	Dose	Route of Admin.	Provider

Suggested - Not In Inventory

_____
Signature of Provider

***Form should be retained as an informed consent**